PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ____/_____/_____

PATIENT NAME: _________________ _________________ ____ DATE OF BIRTH: ____/____/____ AGE: ____ SEX: M F

LAST FIRST MI

HOME ADDRESS: _______________________________________ CITY/STATE: ________________________ ZIP: _____________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_____) _____-________ YES NO

WORK PHONE #: (_____) _____-________ YES NO

CELL PHONE #: (_____) _____-________ YES NO

E-MAIL: ______________________________________ YES NO

PRIMARY LANGUAGE: __________________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: ____________________________ RELATIONSHIP: _____________ PHONE #: (_____) _____-_______

EMERGENCY CONTACT: ____________________________ RELATIONSHIP: _____________ PHONE #: (_____) _____-_______

PRIMARY CARE DOCTOR: ____

PHONE: ___________________________________

PHARMACY: _____________________________ LOCATION: __________________________ PHONE #: (_____) _____-_______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

______ YES NAME(S) ____ ___________

______ NO

WHO IS RESPONSIBLE FOR PAYMENT? ______________________________

RELATIONSHIP TO PATIENT? ________________

ADDRESS: ________________________ CITY/STATE: _________________ ZIP: _________ PHONE #: (_____) _____-______

WHO REFERRED YOU TO US? ____

____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: __________________________ CITY/STATE: __________________ ZIP: __________ PHONE #: (_____) _____-______

INSURED NAME: ____________________________ DATE OF BIRTH _______________ EMPLOYER _____________________________

CONTRACT # ____________________ GROUP # ______________________

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: __________________________ CITY/STATE: __________________ ZIP: __________ PHONE #: (_____) _____-______

INSURED NAME: ____________________________ DATE OF BIRTH _______________ EMPLOYER _____________________________

CONTRACT # ____________________ GROUP # ______________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

____
____
____
____
____
____
____
____
____
____
____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

____
____
____
____
____
____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

____
____
____
____
____
____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE ___________________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? __________ ☐ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _________ TYPE ________________________

☐ CURRENT USE - TYPE _______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: ____ OCCUPATION: ____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _______ ☐ PET(S)–WHAT KIND? ________

☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER ____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

☐ OTHER ____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ____

☐ ANESTHESIA ___________________________________ ☐ FOODS ______________________________________

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ____

☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUXYNFIBROMYALGIAYNNEUROPATHYYNANEMIAYNGOUTYNOPEN SORESYNARTHRITISYNHEART ATTACKYNPNEUMONIAYNASTHMAYNHEART DISEASE/ FAILUREYNPOLIOYNBACK TROUBLEYNHEPATITISYNRHEUMATIC FEVERYNBLADDER INFECTIONSYNHIV+/AIDSYNSICKLE CELL DISEASEYNABNORMAL BLEEDINGYNHIGH BLOOD PRESSUREYNSKIN DISORDERYNBLOOD CLOTSYNKIDNEY DISEASEYNSLEEP APNEAYNBLOOD TRANSFUSIONYNLIVER DISEASEYNSTOMACH ULCERSYNBRONCHITIS/EMPHYSEMAYNLOW BLOOD PRESSUREYNSTROKEYNCANCERYNMIGRAINE HEADACHESYNTHYROID

DISEASEYNDIABETESYNMITRAL VALVE PROLAPSEYNTUBERCULOSISYNOTHER CONDITIONS:

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT **RIGHT FOOT**

HOW LONG AGO DID THIS PROBLEM FIRST START? __________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER

____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING

☐ Daily activities

☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe

☐ Running ☐ Other ____

What makes your pain or problem feel better? ____

What treatments have you had for this problem? ____

How has this problem affected your lifestyle or ability to work? ______________________________

Was this problem caused by an injury? ☐ Yes (describe) ______________________________ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

____

____

Print name of patient, parent or guardian Signature of doctor

____

____

If other than patient, relationship to patient Date

____

Signature

____

Date

Patient Name: ______________________________

Date of Birth: ____/____/_____

Revised April 2013

Revised April 2013

TOP OF FOOT

BOTTOM OF FOOT

BOTTOM OF FOOT

TOP OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT